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Abstract

Research and evaluation have been responsible for not only identifying revolutionary methods of study, but also contributing to progressive changes within these same methods. Continued studies in therapeutic methods that have been used with deaf and hard of hearing populations have shown significant barriers that still exist between the world of the hearing and the world of the deaf. We'll examine how the application Family Preservation/ Multisystemic Therapy (FP/MST) in an intensive home-based format could not only bridge significant shortfalls in service deliveries, but also potentially enhance opportunities for success for persons who are deaf or hard of hearing.

Introduction

Over the past half-century, the concept of empowerment has become the ideal of people who are determined to define their own fates (PEPNet, 2002). During this evolution of social ideals, people with disabilities not only found a way to come together, but they also established a political platform. The Americans with Disabilities Act of 1990 (ADA) transformed the civil rights landscape, mandated equal rights for persons with disabilities, and ensured that adequate and reasonable accommodations would be made to make opportunity available to all.

The ADA, which expanded the Rehabilitation Act of 1973 from government from government to educational institutions, was instrumental in increasing the quantity of services provided for persons with disabilities. However, to this day the quality of services to persons with disabilities falls short of the mark for many different reasons. The primary reasons that services are inadequate stem from service providers' inability to understand the needs of the referral source (one size fits all service), and the apparent inability or unwillingness to adapt and improve services through continued trainings and studies.

In the Postsecondary Education Network's Conference Proceedings for 2002, transitioning people with disabilities was addressed:

"Adolescents with disabilities and their families face many challenges, especially at critical transition points in their lives. Such transitions include moving from middle school to high school, moving

from high school to employment, entering post-secondary education programs, and/or deciding to live independently in the community. The success of each transition is contingent upon the coordination of several factors such as services, experience, and programs that assist individuals in selecting and achieving goals. Due to the diversity of goals, various professionals including special educators, vocational support personnel, employers and community/adult service providers may participate in the transition assessment process. However, success of this depends on the active involvement of the adolescent and his or her family" (PEPNet Conference Proceedings 2002).

In 1997, the Medical University of South Carolina (MUSC) directed a one-year, grant-funded program designed to provide intensive, home-based services for adolescent mothers in an Early Head Start program in Sumter, South Carolina. The MUSC program combined a Family Preservation (FP) model with Multisystemic Therapy (MST). The Family Preservation (FP) model does not embrace any specific treatment method, but accentuates the importance of providing services within the natural environment of clients, for example, in clients' homes or neighborhoods (Henggler & Borduin, 1990). Multisystemic Therapy (MST) is a therapeutic approach used to addressing serious mental health issues of youths and families with multiple service needs (Henggler & Borduin, 1990).

The Medical University of South Carolina (MUSC) program trained counselor-researchers in Family Preservation and Multisystemic Therapy (FP/MST) and delegated the responsibility of providing intensive, home-based services for teen mothers enrolled in Sumter's Early Head Start Program. The purpose of the study was to compare the level of success of young mothers who were receiving FP/MST services to those that were not. At the completion of the study, it was evident that FP/MST intensive home-based services had positively impacted the adolescent participants.

Counselor-researchers were each given five cases in which to work with intensely. The belief was that instead of having a double-digit caseload, workers were to focus on five cases so that the therapist could be exceptionally knowledgeable and accessible. Counselor-researchers were on call 24-hours-a-day in case of emergency, and in the beginning, met with the families daily. The objective (following intake and assessment) was to take an unprecedented approach to counseling by understanding the issues facing the clients and their families, and by

understanding any environmental customs, interpersonal relationships, or other idiosyncrasies that might affect the clients or their families.

The level of each client's therapeutic progress was determined from the perspective of goal achievement, as well as the time frames in which goals were completed. By meeting with a counselor daily, time frames were condensed. Instead of seeing clients one time per week and working toward a goal for at least a month, daily meetings allowed goals to be accomplished in half the time. Daily "assignments" towards mutually identified goals enabled clients and their families to achieve small successes through completing intermediary goals, and long term successes by staying focused on the overarching goals.

As a clinical counselor for the better part of five years after MUSC's year-long FP/MST pilot project was completed, opportunities to work with persons who had a wide variety of disabilities, such as addiction, mental health, and other disorders were pursued. Katie was a new referral and happened to be deaf. Not having worked with anyone who was deaf or hard of hearing before, there can at times be some hesitancy about service provision to someone without full communication. After first experiencing discomfort and avoidance, we slowly began writing notes. Through the state Vocational Rehabilitation Office, access to the University of Tennessee for a five-week training entitled Orientation to Deafness was provided. The orientation training provided opportunities to acquire sign language skills and learn about the Deaf Culture and Community. Within the Deaf Community, there is social strength, political activism, and agreat sense of pride evident in all who are involved. You can't just try Deaf Culture! Immersion with the language, mores, and active partnership with the Deaf Community are also required to engage in Deaf Culture.

This method of training made evident how far behind society is in terms of the quality of available services for persons who are deaf and hard of hearing. At Vocational Rehabilitation, there are counselors that have sign language skills; however, the people that are actually teaching job skills often can not communicate with deaf clients. Often, it seems that significant communication shortfalls are present between the worlds of the deaf and hard of hearing and hearing service providers. Of the existing mental health and addiction-focused social services, what resources are available to help professionals in these areas provide quality services to persons who are deaf and hard of hearing? Service delivery systems for the deaf and hard of hearing have improved and will continue to improve, however, it is essential to identify counselors who

have an honest desire to work with persons who are deaf and hard of hearing if the quality of services is to truly improve on a long-term scale.

To illustrate the theory of improved service delivery equaling more desirable outcomes, the Family Preservation/ Mutisystemic Therapy model could be applied to the deaf and hard of hearing population. Cluster samples are recommended with each to include three diverse sets of families: 1) deaf parents with hearing children; 2) hearing parents of deaf children, and; 3) deaf parents of deaf children. Using a variety of participants and families would provide well-rounded data for review, and would also allow the principal investigator to compare and contrast the effectiveness of FP/MST on a number of possible family structures, in terms of hearing status. Ideally, a total of 36 families would be sampled, with each of the four participating therapists managing nine cases consisting of three families with hearing parents of deaf children, three families with deaf parents of hearing children, and three families with deaf parents of deaf children. There should be no more than five families being seen intensively at one time by each therapist. That does not mean that a therapist would only have communication with five families for the duration of the study. This simply means that a therapist may have five families that he or she is working with intensively, and five families that are strictly in case management status. "Case management families" will be met with periodically for general case maintenance, coordination of services if necessary, and if applicable, continuum of care. Throughout the study, routine documentation and case reviews will take place between the therapist, clinical supervisor, and treatment team. These measures are designed to provide quality assurance and to assure that appropriate therapeutic services are being provided.

Expected Results

It is expected that the application of this therapeutic model will yield valuable information addressing differentiation in the success rates of the various family structures. For example: hearing parents of deaf children, deaf parents of hearing children, and deaf parents of deaf children may progress at different rates and respond to techniques differently. Other variables to be examined are enrollments in residential schools for deaf children and in mainstream or public schools, and the success rates of Family Preservation (or cohesion) within the test families regardless as to whether residential or mainstream schools are chosen.

Participant case files should include referral information, an intake, a psychosocial assessment, insurance information, a confidentiality agreement, a signed informed consent form, a treatment plan, and daily log or documentation sheets. The daily documentation sheets should consistently refer back to the intermediary and overarching goals. The purpose for this is to maintain focus on the treatment regimen and to ensure reimbursement by the insurance provider. This practice keeps the therapist and target family focused and allows a treatment team member and/or clinical supervisor the ability to accurately assess the progress of the test case at any given time.

The goals of this intervention are twofold: 1) maintain focused on giving target families the resources and knowledge to improve their continuity, acquire adequate knowledge of community based resources, and learn how to access those resources in the absence of therapeutic intervention; 2) provide an educational component for service providers in which coordination of services takes place, such as schools, agencies, and businesses.

This is of paramount importance, to not only the families who are receiving the services, but also to the deaf and hard of hearing individuals (or families) that attempt to acquire services in the future. This training for service providers (or businesses) gives them insight into who they are serving, how they need to be served, and hopefully, will contribute to positive long term progression and inclusion of the deaf and hard of hearing in the mainstream service providing.

The proposed application would essentially yield the following results:

Early informed choices will be made as to whether to send deaf children to residential schools for mainstream them into public schools. When there is a consensus as to the educational path for the child, strengths and need areas will be addressed by the child, family, therapist and relevant educators within the school of choice. This will in the long run create both educational and social stability for the child (e.g. not moving in and out of residential and mainstream schools as a result of not making an informed decision), as well as the parents knowing and understanding the importance and impact of the decision they are making.

Due to the deaf and hard of hearing families having an intermediary between them and educational institutions, post-secondary

numbers will show signs of steady improvement. Both admissions to institutions of higher learning and 4-year completions (to include graduation) would show signs of improvement respectfully.

Vocational objectives and achievements for individual family members would improve as a result of information becoming available to the families, and also having an advocate to assist them in identifying and eliminating potential barriers. Educational and vocational testing scores for individual family members would improve as a result of the therapist educating both schools and businesses as to the appropriate ways to test the deaf and hard of hearing. It is important to remember that Multisystemic Therapy in a Family Preservation format encompasses assisting the entire family unit if possible. Therefore, the strength of the unit does not depend on one individual improving, it depends on a holistic approach that enables all members of the unit to improve.

"Assessment and placement of deaf children and adults in appropriate programs, staffed by trained and caring professionals using effective communication, is a battle that has not been won." (PEPNet, 2002) The intense contact and treatment of this model has the ability, through informed choice and active participation, to arm the deaf and hard of hearing individual with the information and opportunities that could provide the platform for significant educational and vocational advancement.

One way this advancement could take place is in the educational arena. For example, not understanding the way a student communicates or learns affects education in a multitude of ways. First, if a student is tested in a language in which he or she is not proficient, scores will be significantly lower than if a student is able to fully understand the instructions as well as the questions. Some deaf students, as a result of lower reading and reading comprehension abilities, may not be able to effectively read test questions. However, if a sign language interpreter translates the questions to the deaf student using his or her language, the student has an increased potential to comprehend the questions accurately. By taking the time to educate teachers and administrators on how deaf and hard of hearing students learn best, more appropriate placement would occur, test administering would be adjusted, and more students would realize their learning potential instead of being placed in special education. This would be a major achievement for deaf and hard of hearing students.

The second goal is helping parents to make informed choices about important decisions. Since all children must go to school, establishing (early in the child's education) student placement in a residential school for the deaf or mainstreaming into a public school is an issue that would require the attention of the family unit. This is an important decision, because a student's level of comfort, cognition, and confidence are established during the early stages of education. If a student fares well early on in the educational process, he or she has the potential for a bright educational future. Conversely, if students do not fare well, they may get labeled as poor achievers and become limited as to what they are able to achieve academically. As important as this decision is, it is equally important that the family structure makes this decision, not the therapist. Since the goal is independence, the family unit must ultimately make a decision that they are both comfortable and responsible for. This will not only strengthen communication among the family and its individual members, but it will also limit the liability of a therapist making "recommendations".

Thirdly, the numbers associated with post-secondary education (from initial acceptance to graduation) will significantly improve. According to PEPNet, the following statistics hold true:

Hearing students:	58% withdrawal rate at 2-year colleges
	30% withdrawal rate at 4-year colleges
Deaf students:	66% withdrawal rate at 2-year colleges
	72% withdrawal rate at 4-year colleges

By looking at these numbers, it is evident that there is cause for concern. Different colleges and universities have a variety of disability services. Jacksonville State University has numerous accommodations for deaf and hard of hearing students: interpreting, note taking, real-time captioning, C-print, and counseling services. Although these services are not at all revolutionary especially in an academic setting, not all colleges and universities are equipped with these services. Can you imagine what it would be like to go to a class, understand only one fourth to half of the information, and then attempt to pass the class? It would be a difficult mission, if not impossible, and the result would likely be the student dropping out of school. If a therapist were to assist the client in getting all available information about a higher institution's disability services, the student would have an idea about the resources available, and in turn,

he or she would be ensured of the best opportunity for academic success in terms of accommodations.

The fourth and final focal point of this study would be to improve the vocational landscape of the deaf and hard of hearing community. In 1999, Geyer and Schroedel published an article in the Journal of Rehabilitation titled "Conditions influencing the availability of accommodations for workers who are deaf of hard of hearing" The premise of this article chronicled a study detailing conditions that influence accommodations for workers who are deaf or hard of hearing. Limited data on the relationship between employer attributes and the availability of accommodations has been published. Researchers studied perceptions of 367 employers toward accommodating workers with disabilities and found that company size (as measured by the number of workers) was related to favorable attitudes about accommodations. Larger firms were more supportive than smaller firms, a finding which supports the theoretical work of Stone and Colella (1996), who predicted that legislation will affect the development of personnel policies and procedures. It follows from this theory that, since the ADA legislation does not apply to companies with fewer than 15 workers, smaller-sized companies would be less likely to have set procedures for ADA compliance and, thus, would be less likely to be in compliance." This may not seem like a big deal on the front end, but as we look at vocational placements of the deaf and hard of hearing, we see that these individuals are generally underemployed. One potential reason for this is because some deaf persons are unaware of which companies will make optimum provisions to assist with the communication barriers that exist between them and hearing persons. If the identified client, therapist, and other referral sources are able to collaborate for the sake of locating adequate vocational accommodations, there is a distinct possibility that deaf and hard of hearing clients would be able to work in a comfortable and sensitive work environment.

As progress is discussed in society, the main factors that influence it revolve around education, vocation, political advocacy, and social affiliation. None of these factors can be positively influenced by exclusion. A social responsibility remains to all who work with and support those with disabilities to make sure that people with disabilities, specifically deaf and hard of hearing persons, have equal access to resources. In an interview that was done with a deaf client at Vocational Rehabilitation, she stated, "deaf people don't like when the hearing make decisions for them. We want to be able to make our own decisions instead of having someone tell us what's best for us." It's time to change

the way we look at service delivery to deaf persons. Therapeutic advancement currently stands before us. There are currently no studies or data available that addresses or emphasizes the effects of intensive home based therapy with deaf and hard of hearing families. As researchers and therapists, we have the opportunity to assist deaf and hard of hearing persons in ways that have never been attempted before, while simultaneously evolving the way in which service delivery is provided in the future.

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Bibliography

Bullis, M, Davis, C. (1995) Transitioning achievement among young adults with deafness: What variables relate to success? *Rehabilitation Counseling Bulletin, 39*, 130. Retrieved June 10, 2005, from EbscoHost database.

Davila, R. (2002). Taking stock of our present and projecting the future. Tennessee: Postsecondary Education Consortium. Published by University of Tennessee Center on Deafness and PostSecondary Education Consortium. (Publishing information furnished by The University of Tennessee)

Garay, S. (2002). Transition planning process: Giving deaf students a voice. Tennessee: Postsecondary Education Consortium. Published by University of Tennessee Center on Deafness and PostSecondary Education Consortium. (Publishing information furnished by The University of Tennessee)

Gentry, Mary M; Chinn, Katherine M; Moulton, Robert D. Effectiveness of the multimedia reading materials when used with children who are deaf. *American Annals of the Deaf, 149*, 394. Retrieved June 15, 2005, from EbscoHost database.

Geyer, P. & Schroedel, J. (1999). Conditions influencing the availability of accommodations for workers who are deaf of hard of hearing. *The Journal of Rehabilitation, 65*, 42. Retrieved April 3, 2004, from EbscoHost database.

Guteng, Simon I. (2005). Professional concerns of the beginning teachers of deaf and hard of hearing students. *American Annals of the Deaf, 150*, 17. Retrieved June 20, 2005, from EbscoHost database.

Henggeler, S. (1994). Treatment manual for family preservation using multisystemic therapy. Published at The Medical University of South Carolina through The South Carolina Health and Human Service Commission (publishing information furnished by The Medical University of South Carolina).

LeBlanc, Barbara M. (2004). A public school cued speech program for children with hearing loss and special learning needs. *Volta*

Review, 104, 327. Retrieved June 09, 2005, from EbscoHost database.

Luckner, John L, Velaski, Ann. (2004) Healthy families of children who are deaf. *American Annals of the Deaf, 149*, 325. Retrieved July 1, 2005, from EbscoHost database.

Luterman, David. Emotional aspects of hearing loss. *Volta Review, 99*, 75. Retrieved July 5, 2005, from EbscoHost database.

Mezack, K. A specialized approach to job readiness training. *American Rehabilitation, 21,* 29. Retrieved June 20, 2005, from EbscoHost database.

Moore, Corey L. Disparities in job placement outcomes among deaf, late-deafened, and hard of hearing consumers. *Rehabilitation Counseling Bulletin, 44,* 144. Retrieved June 13, 2005, from EbscoHost database.

Senghas, R. Signs of their times: Deaf communities and the culture of language. *Annual Review of Anthropology, 31,* 69. Retrieved June 23, 2005, from EbscoHost database.